Team Name: Critical Care Medical Team Team Lead: Director - Acute Community Hospitals Approved by: Regional Lead - Acute Care & Chief Nursing Officer	Reference Number: CLI.4510.PL.005 Program Area: Across Hospital Units Policy Section: General
Issue Date: June 20, 2018 Review Date: Revision Date: October 13, 2023	Subject: Information Transfer at Care Transition - Acute Care

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POLICY SUBJECT:
Information Transfer at Care Transition - Acute Care

PURPOSE:
To promote patient safety by implementing effective transfer of information at care transitions through standardized approaches in all acute care sites.

BOARD POLICY REFERENCE:
Executive Limitations (EL-01) Global Executive Restraint & Risk Management
Executive Limitations (EL-02) Treatment of Clients

POLICY:
Program approved standardized documentation tools and processes for transfer of information at care transitions are utilized to maintain safe and coordinated processes, and continuity of care between providers when the patient experiences a change in health status, care needs, or location. This includes sharing of key information to immediately identify and prioritize patient care needs and monitoring requirements.

Providers of care derive reliable knowledge from scientific sources, professional experiences, subjective experiences, and ethics. The culmination of knowledge gained from these sources is tacit knowledge, expressed as a provider's foresight, intuition and gut sense that guides continued critical thinking and decision-making around what to be worried about, what could go wrong, and what to look out for. This is a critical component within information transfer at care transition.

Documented information is required at care transition involving admission, transfer or discharge to other units, programs or services, and is included as a component of the health record.

Patients and families are supported during care transitions and given information that they need to make decisions and support their own care.

Information shared aligns with the Personal Health Information Act and Southern Health-Santé Sud policies and procedures.

DEFINITIONS:

Care transition - any point in care when one care provider is transitioning care responsibility to another care provider (i.e. at admission, transfer, discharge and handover).

Handover - information transfer from one provider to another assuming responsibility of care within the same care location and includes but is not limited to transferring responsibility of care between shifts or for shorter periods of time - such as breaks or change in care assignments.

Health care provider - all individuals who provide direct or indirect care as a result of their position and role in patient care.

Information transfer - communication at care transitions of pertinent information relevant to the care of the patient to assist the receiving provider to immediately identify and prioritize ongoing care needs and monitoring requirements.

SBAR - an acronym for Situation, Background, Assessment, Recommendation(s). The SBAR-Clinical (CLI.4110.PL.010.FORM.01) and SBAR-Clinical: Acute Care (CLI.4510.PL.005.FORM.02) are tools to guide the organization of pertinent patient information, verbally or in writing, to support information transfer at care transitions or for consultation with another health care provider (i.e. nurse to physician).

IMPORTANT POINTS TO CONSIDER:

Information transfer supports safe patient care by providing information reflective of critical inquiry, emphasizing critical thinking and clinical judgment, informed by the condition and care needs of the patient.

- Patient/designate involvement is an essential component of information transfer and includes providing them with information that they need to support and guide their care/health journey.

It is recognized that there will be situations where exceptions to this policy will be necessary for best patient care. These exceptions must be justified and documented in the health record.

PROCEDURE:

1. For all patients who access acute care facilities arranged by external care providers (i.e. as per Referral to Emergency Department or an Alternate Care Provider (CLI.4110.SG.001) policy) and information relevant to their care is unclear, consult with the appropriate provider to clarify, identify, and prioritize monitoring and care needs.
2. Admissions:

2.1. For patients who present to the emergency department (ED), sources of information at the point of entry are the patient, designate(s) and, if applicable, Emergency Response Services (ERS) personnel.
   - When patient arrives via ERS, transfer of information includes a verbal report provided by ERS Paramedic to ED nurse/physician and a written ERS Patient Care Report.
   - A transfer of care is complete when the ED nurse/physician signs the ERS Patient Care Report.

2.2. For admission from the ED to inpatient units and transfer of information between primary care providers:
   - Written prescriber orders and a health history inform the reason for admission and monitoring needs.
   - Complete the SBAR-Clinical: Acute Care (CLI.4510.PL.005.FORM.02) and provide a nurse-to-nurse verbal report prior to transfer from ED to the inpatient unit.

2.3. For direct admissions to hospital units (e.g. inpatient units; same day surgery):
   - Written prescriber orders and a health history inform the reason for admission, and care and monitoring needs.

3. Transfers:

3.1. Interfacility transfers (from one facility to another):
   - Follow Information Transfer at Care Transition – Interfacility Transfer (CLI.4110.PL.007) policy.
     - As the sending facility, complete the Manitoba Information Transfer Referral Form (CLI.4110.PL.007.FORM.01) as per Manitoba Information Transfer Referral Form Guidelines for Completion (CLI.4110.PL.007.SD.01).
   - When a nurse from Southern Health-Santé Sud accompanies the patient on the inter-facility transfer:
     - Use the Nurse Escort Interfacility Transfer Record (CLI.4110.PL.007.FORM.02) for documenting and refer to Nurse Escort Interfacility Transfer Record: Directions for Use (CLI.4110.PL.007.SD.02).
   - For patients returning to another facility and whose stay is less than 24 hours, complete only the "Discharge Summary and Recommendations" section on *Manitoba Information Transfer Referral Form* if it adequately captures patient's current needs.
   - For transfers delayed greater than 12 hours:
     - Reassess patient status for:
       - Changes in the severity of their condition and
       - Appropriateness of level of transfer method (i.e. stretcher service vs ERS).
     - Contact MTCC re update on estimated transport time
     - Inform Primary Care Provider of any concerns/issues related to the patient's status and/or transportation concerns.

3.2. Transfers from one unit to another:
   - Use SBAR-Clinical: Acute Care (CLI.4510.PL.005.FORM.02) to capture the situation, background, assessment, and recommendations of critical and relevant information.
     - Keep the SBAR-Clinical: Acute Care (CLI.4510.PL.005.FORM.02) as part of the health record.

- The intent of the SBAR-Clinical is not to replicate information that is readily available in a kardex, care plan, and other documents. It involves communicating the information needed by the accepting provider to maintain continuity of care, and prioritize monitoring and care needs.

- SBAR-Clinical: Acute Care (CLI.4510.PL.005.FORM.02) can be tailored with cues for core information to be reported for specific programs (i.e. obstetrics). However, all tailored SBAR-Clinical documents **must be approved** by the regional acute care team prior to implementation.

➢ Provide verbal nurse-to-nurse report.

4. Discharges back to community from the emergency department:
   4.1. For self-care, provide patient/designate with discharge instructions.
   ➢ As per Discharge Instructions: Emergency Department (CLI.5110.PR.012) guidelines, document patient discharge instructions on Discharge Instruction Record: Emergency Department (CLI.5110.PR.012.FORM.01) and provide a copy to the patient/designate.
   ➢ From EDs with Emergency Department Information System (EDIS), complete the discharge instructions and print copy/copies for the patient/designate.
   4.2. For transfer of care back to community primary care providers, provide information transfer through:
   ➢ Discharge summary from the ED visit.
   - From EDs with EDIS, these are automatically faxed directly to the primary care provider.
   - From non-EDIS sites, Health Information Services (HIS) staff makes a copy of the ED facesheet and faxes to primary care provider.

   ➢ Written discharge instructions are provided to the patient/designate.
   - Providing discharge instructions to patient/designate is a shared responsibility between physician and nurse or other providers involved in the patient's discharge.

   4.3. For referral to other community programs or specialty services:
   ➢ Complete the applicable program-specific referral form. For example: home care referral form; outpatient rehabilitation services.
   ➢ Provide a verbal report as indicated/required based on the patient's needs.
5. Discharges from inpatient units:
   5.1. For self-care, provide and review with patient/designate written the Hospital Discharge Instruction Plan (CLI.4510.PL.005.FORM.01) and, as per the Medication Reconciliation (CLI.6010.PL.009) policy, provide a Discharge Medication Plan (CLI.6010.PL.009.FORM.02). Retain a copy of the Hospital Discharge Instruction Plan and the Discharge Medication Plan and Prescription on the patient chart for future reference.
   5.2. For transfer of care back to community primary care providers:
   ➢ Admitting physician – dictate a discharge summary, which is then autofaxed to primary care provider.
   5.3. For referral to other community programs or specialty services:
   ➢ Complete the applicable program-specific referral form. For example: home care referral form; outpatient rehabilitation service; mental health adult referral form; and public health Post-Partum Referral Form.

- Provide a verbal report as indicated/required based on the patient's needs.

6. Handover: Involves a transfer of care from one provider to another within the same care location.
   6.1. Break time relief:
   - Provide a brief verbal report that targets at risk patients and include any assessments and interventions to be completed while you, the assigned nurse, is away from the unit.

   6.2. Shift to shift:
   - Bedside reporting between the outgoing and incoming care providers and the patient/designate is conducted. Bedside reporting is best practice and ensures key information sharing regarding patient condition, care and goals of care. It supports patient engagement and enhances patient care.
   - Minimal information to be communicated includes:
     - Patient identifier
     - The situation, defined as the current patient status. This includes any abnormal findings; pertinent normal findings within the context of positive changes in health status; pain and other symptom management interventions and outcome.
     - Background: brief history relevant to current condition and contributing factors; patient/family concerns; providers involved in the care if applicable.
     - Assessment: based on the information provided under the situation and background, identify current active patient issues and assessment findings.
     - Recommendations: plan of care that includes interventions to address active patient issues identified, upcoming procedures, special monitoring and discharge plan.
   - At the Regional Sites – ED, conduct a Team Huddle/Running of the Board at the start of each shift and throughout the shift as deemed applicable with physicians and the triage nursing staff to review the patients in the waiting room that need to be seen and determine if treatment of some patients can be initiated in other care areas.
   - At Acute Community - ED sites, conduct a Team Huddle/Running of the Board at the start of each shift and throughout the shift when there are multiple patients in the waiting area and there are delays in care. The physician and triage nurse review the patients in the waiting room that need to be seen and prioritize accordingly.

Quality Improvement

Annually complete the following:

1. Information Transfer Acute Care Audit for Internal Transfers (CLI.4510.PL.005.FORM.03) as a retrospective audit of 10 charts of patients who were admitted to inpatient units from ED or unit-to-unit transfers.
2. Information Transfer Acute Care Audit for Interfacility Transfers (CLI.4510.PL.005.FORM.04) as a retrospective audit of 10 charts of patients that capture interfacility transfers.
3. For handover, use the Information Transfer Acute Care Audit for Handover of Care (CLI.4510.PL.005.FORM.05) and conduct audit at shift change, for break relief, and for other circumstances when verbal report is provided.

4. Information Transfer Acute Care Audit for Discharges (CLI.4510.PL.005.FORM.06) as a retrospective audit of 10 patient charts who were admitted and discharged home.

Annually review the results of the Canadian Patient Experience Survey – Inpatient Care (CPES-IC) to evaluate individual patient experiences and develop a site improvement plan.

The local interdisciplinary team reviews audit results, identifies opportunities for improvement and develop an action plan. The results and the action plan are submitted to the respective program.

SUPPORTING DOCUMENTS:

CLI.4510.PL.005.FORM.01	Hospital Discharge Instruction Plan
CLI.4510.PL.005.FORM.02	SBAR-Clinical: Acute Care
CLI.4510.PL.005.FORM.03	Information Transfer Acute Care Audit for Internal Transfers
CLI.4510.PL.005.FORM.04	Information Transfer Acute Care Audit for Interfacility Transfers
CLI.4510.PL.005.FORM.05	Information Transfer Acute Care Audit for Handover of Care
CLI.4510.PL.005.FORM.06	Information Transfer Acute Care Audit for Discharges
CLI.4110.PL.007	Information Transfer at Care Transition – Interfacility Transfer
CLI.4110.PL.007.FORM.01	Manitoba Information Transfer Referral Form
CLI.4110.PL.007.FORM.02	Nurse Escort Interfacility Transfer Record
CLI.4110.PL.007.SD.01	Manitoba Information Transfer Referral Form Guidelines for Completion
CLI.4110.PL.007.SD.02	Nurse Escort Interfacility Transfer Record: Directions for Use
CLI.4110.SG.001	Referral to Emergency Department or Alternate Care Provider
CLI.4110.PL.010.FORM.01	SBAR-Clinical
CLI.5110.PR.012	Discharge Instructions: Emergency Department
CLI.5110.PR.012.FORM.01	Discharge Instruction Record
CLI.6010.PL.009	Medication Reconciliation
CLI.6010.PL.009.FORM.02	Discharge Medication Plan and Prescription

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